Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Durable medical equipment (DME)	You Pay	
	Standard Option	**Basic Option**
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment. Under this benefit, we cover: • Home dialysis equipment • Oxygen equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Continuous passive motion (CPM) and dynamic orthotic cranioplasty (DOC) devices • Other items that we determine to be DME, such as compression stockings ***Note:*** We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers. ***Note:*** See Section 5(c) for our coverage of DME provided and billed by a facility.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: • *Exercise and bathroom equipment* • *Lifts, such as seat, chair, or van lifts* • *Car seats* • *Air conditioners, humidifiers, dehumidifiers, and purifiers* • *Breast pumps* • *Communications equipment, devices, and aids (including computer equipment) such as "story boards" or other communication aids to assist communication-impaired individuals* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)*	*All charges*	*All charges*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Medical supplies	**You Pay**	
	Standard Option	**Basic Option**
• Medical foods for children with inborn errors of amino acid metabolism • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Ostomy and catheter supplies • Oxygen, regardless of the provider • Blood and blood plasma, except when donated or replaced, and blood plasma expanders ***Note:*** We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Home health services		
Home nursing care for two (2) hours per day, up to 25 visits per calendar year, when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.	Preferred: $20 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter*	*All charges*	*All charges*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Chiropractic	You Pay	
	Standard Option	**Basic Option**
• Initial office visit • Spinal manipulations • Initial set of X-rays *Note:* Benefits may be available for other covered services you receive from chiropractors in medically underserved areas. See page 10 for additional information.	Preferred: $15 copayment per visit (No deductible) Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount *Note:* Benefits are limited to 10 manipulations per calendar year. *Note:* Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred: $20 copayment per visit *Note:* Benefits are limited to 20 manipulations per calendar year. Participating/Non-participating: You pay all charges
Alternative treatments		
Acupuncture *Note:* See page 57 for our coverage of acupuncture when provided as anesthesia for covered surgery. *Note:* See page 32 for our coverage of acupuncture when provided as anesthesia for covered maternity care. *Note:* We may also cover services of certain alternative treatment providers in medically underserved areas. See page 10 for additional information.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount *Note:* Acupuncture must be performed and billed by a physician or licensed acupuncturist. *Note:* Benefits for acupuncture are limited to 10 visits per calendar year. *Note:* Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred primary care physician: $20 copayment per visit Preferred physician specialist: $30 copayment per visit *Note:* You pay 30% of the Plan allowance for drugs and supplies. *Note:* Acupuncture must be performed and billed by a physician. Participating/Non-participating: You pay all charges
Not covered: • *Services you receive from noncovered providers such as:* – *naturopaths* – *hypnotherapists* • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Educational classes and programs	You Pay	
	Standard Option	**Basic Option**
• Smoking cessation *Note:* See Section 5(e) for our coverage of individual and group psychotherapy for smoking cessation and Section 5(f) for our coverage of smoking cessation drugs.	Preferred: $15 copayment for the office visit charge (No deductible); 10% of the Plan allowance for all other services (deductible applies) Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
• Diabetic education when billed by a covered provider *Note:* We cover diabetic educators, dieticians, and nutritionists who bill independently only as part of a covered diabetic education program. • Nutritional counseling for up to 4 visits per year when billed by a covered provider *Note:* Nutritional counseling for the treatment of anorexia and bulimia is not subject to the 4-visit limitation. *Note:* We cover dieticians and nutritionists who bill independently for nutritional counseling.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount *Note:* Nutritional counseling visits (for other than anorexia and bulimia) that you pay for while meeting your calendar year deductible count toward the 4-visit limit.	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation, headache, eating disorder (except as described above), and other educational clinics* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Services performed or billed by a school or halfway house or a member of its staff*	*All charges*	*All charges*

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $250 per person ($500 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We say "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Standard Option,** we provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See below and page 11 for the exceptions to this requirement.**
- **Under Basic Option,** we provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service.
- The amounts listed in this section are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants);** and if your surgical procedure requires an inpatient admission, **YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.		
Surgical procedures	**Standard Option**	**Basic Option**
A comprehensive range of services provided, or ordered and billed by a physician, such as: • Operative procedures • Treatment of fractures and dislocations, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Colonoscopy – diagnostic • Other endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery on page 48) • Treatment of burns • Circumcision of newborn • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices, and Section 5(c) – Other hospital services and supplies – for our coverage for the device. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Assistant surgeons/surgical assistance by a physician if required because of the complexity of the surgical procedures • Gastric bypass surgery or gastric stapling procedures for morbid obesity – a condition in which an individual weighs 100 pounds over, or 100% over, his or her normal weight according to current underwriting standards; eligible members must be age 18 or over	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Surgical procedures – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Surgical procedures *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Note: When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure. *Note:* We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care). *Note:* When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.		
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician* • *Routine surgical treatment of conditions of the foot [see Section 5(a) – Foot care]* • *Cosmetic surgery* • *LASIK, radial keratotomy, and other refractive surgery*	*All charges*	*All charges*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Reconstructive surgery	You Pay	
	Standard Option	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. ***Note:*** Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth. • Treatment to restore the mouth to a pre-cancer state • All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance of the patient's breasts – treatment of any physical complications, such as lymphedemas ***Note:*** Internal breast prostheses are paid as orthopedic and prosthetic devices [see Section 5(a)]. See Section 5(c) when billed by a facility. ***Note:*** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Not covered: • *Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)* • *Surgeries related to sex transformation, sexual dysfunction, or sexual inadequacy (except for surgical placement of penile prosthesis to treat erectile dysfunction resulting from prostatectomy to treat prostate cancer)*	*All charges*	*All charges*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Oral and maxillofacial surgery	You Pay	
	Standard Option	**Basic Option**
Oral surgical procedures, limited to: • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries (see Definitions) to jaws, cheeks, lips, tongue, roof and floor of mouth • Excision of exostoses of jaws and hard palate • Incision and drainage of abscesses and cellulitis • Incision and surgical treatment of accessory sinuses, salivary glands, or ducts • Reduction of dislocations and excision of temporomandibular joints • Removal of impacted teeth ***Note:*** Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Not covered: • *Oral implants and transplants* • *Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except as shown above and in Section 5(h)* • *Surgical procedures involving orthodontic care, dental implants, or preparation of the mouth for the fitting or the continued use of dentures, except as specifically shown above and in Section 5(h)*	*All charges*	*All charges*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants	You Pay	
	Standard Option	**Basic Option**
Note: You must obtain prior approval (see page 14) for those transplants listed under "**Prior Approval Requirements**" on page 52. *Note:* Refer to pages 12-13 for information about precertification of inpatient care.		
• Cornea • Heart • Heart-lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Single, double, or lobar lung • Double lung: only for patients with end-stage cystic fibrosis	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon *Note:* If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Blood or marrow stem cell transplants, limited to: • Allogeneic blood or marrow stem cell transplants for: – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Advanced forms of myelodysplastic syndromes – Advanced Hodgkin's lymphoma – Advanced neuroblastoma – Advanced non-Hodgkin's lymphoma – Chronic myelogenous leukemia – Infantile malignant osteopetrosis – Kostmann's syndrome – Leukocyte adhesion deficiencies – Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) – Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) – Myeloproliferative disorders	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon *Note:* If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Blood or marrow stem cell transplants, limited to: *(continued)* • Allogeneic blood or marrow stem cell transplants for: – Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) – Severe combined immunodeficiency – Severe or very severe aplastic anemia – Sickle cell anemia – Thalassemia major (homozygous beta-thalassemia) – X-linked lymphoproliferative syndrome • Autologous blood or marrow stem cell transplants for: – Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia – Advanced Hodgkin's lymphoma – Advanced neuroblastoma – Advanced non-Hodgkin's lymphoma – Amyloidosis – Ependymoblastoma – Ewing's sarcoma – Medulloblastoma – Multiple myeloma – Pineoblastoma – Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Prior approval requirements: You must obtain prior approval (see page 14) from the Local Plan, for both the procedure and the facility, for the following transplant procedures: • Blood or marrow stem cell transplant procedures *Note:* See pages 53, 54, and 55 for services related to blood or marrow stem cell transplants covered under clinical trials. • Autologous pancreas islet cell transplant • Heart • Heart-lung • Intestinal transplants (small intestine with or without other organs) • Liver • Lung (single, double, or lobar) • Pancreas • Simultaneous pancreas-kidney		

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Blood or marrow stem cell transplants covered under clinical trials: (1) For the following procedures, we provide benefits **only** when conducted at a Cancer Research Facility (see page 11) and only when performed as part of a clinical trial that meets the **requirements** listed on page 54: • Allogeneic blood or marrow stem cell transplants for: – Chronic lymphocytic leukemia – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma – Multiple myeloma • Nonmyeloablative allogeneic blood or marrow stem cell transplants for: – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Advanced forms of myelodysplastic syndromes – Advanced Hodgkin's lymphoma – Advanced non-Hodgkin's lymphoma – Chronic lymphocytic leukemia – Chronic myelogenous leukemia – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma – Multiple myeloma – Myeloproliferative disorders – Renal cell carcinoma • Autologous blood or marrow stem cell transplants for: – Breast cancer – Chronic lymphocytic leukemia – Chronic myelogenous leukemia – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma – Epithelial ovarian cancer ***Note:*** If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the **requirements** shown on page 54 is not available at a Cancer Research Facility where you are eligible, we will arrange for the transplant to be provided at a transplant facility designated by the Transplant Clinical Trials Information Unit.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
(2) For the following procedures, we provide benefits **only** when performed in a specific NIH-sponsored, randomized, multi-center, comparative clinical trial and when the **requirements** listed below are met: • Autologous blood or marrow stem cell transplants for the following autoimmune diseases: – Multiple sclerosis – Systemic lupus erythematosus – Systemic sclerosis	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
(3) **Requirements** for blood or marrow stem cell transplants covered under clinical trials: For these blood or marrow stem cell transplant procedures and related services or supplies covered only through clinical trials: • You must contact our Transplant Clinical Trials Information Unit at 1-800-225-2268 for prior approval (see page 14); • The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility where the procedure is to be delivered; and • The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial.		

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous blood or marrow stem cell transplant • Harvesting, immediate preservation, and storage of stem cells when the autologous blood or marrow stem cell transplant has been scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed at the time of harvesting with one of the conditions listed on pages 51, 53, or 54 *Note:* Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or anticipated to be scheduled within an appropriate time frame. No benefits are available for any charges related to fees for long term storage of stem cells. • Collection, processing, storage, and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed with one of the conditions listed on pages 50, 51, 53, or 54 • Related medical and hospital expenses of the donor, as part of a covered blood or marrow stem cell transplant procedure • Related services or supplies provided to the recipient *Note:* See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon *Note:* If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants *(continued)*

Organ/Tissue Transplants at Blue Quality Centers for Transplant (BQCT)

We participate in the Blue Quality Centers for Transplant (BQCT), a centers of excellence program for the organ/tissue transplants listed below. You will receive enhanced benefits if you use a BQCT facility.

All members (including those who have Medicare Part A or another group health insurance policy as their primary payer) must contact us at the customer service number listed on the back of their ID card before obtaining services. You will be referred to the designated Plan transplant coordinator for information about BQCT and approved facilities.

- Heart
- Heart-lung
- Liver
- Pancreas
- Simultaneous pancreas-kidney
- Single or double (bilateral) lung
- Lobar transplant (living donor lung)
- Blood or marrow stem cell transplants listed on pages 50, 51, 52, 53, and 54
- Related transplant services listed on page 55

Note: Benefits for cornea, kidney-only, and intestinal transplants are not available through BQCT. See page 50 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: Members will not be responsible for separate cost-sharing for the included professional services (see page 11).

Note: See pages 50, 51, 52, and 53 for requirements related to blood or marrow stem cell transplant coverage.

Note: See page 11 for special instructions regarding all admissions to BQCT institutions.

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, except those performed for full siblings or the unrelated actual donor*	*All charges*	*All charges*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Anesthesia	You Pay	
	Standard Option	**Basic Option**
Anesthesia (including acupuncture) for covered surgical services when requested by the attending physician and performed by: • a certified registered nurse anesthetist (CRNA), or • a physician other than the operating physician (surgeon) or the assistant Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness. ***Note:*** See Section 5(c) for our payment levels for anesthesia services billed by a facility.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section, unlike Sections 5(a) and 5(b), the **Standard Option** calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)" when it applies. The calendar year deductible is $250 per person ($500 per family) under Standard Option.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 11 for the exceptions to this requirement.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed in this section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your inpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.		
Inpatient hospital	**Standard Option**	**Basic Option**
Room and board, such as: • semiprivate or intensive care accommodations • general nursing care • meals and special diets ***Note:*** We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on a per diem amount for your type of admission. Please see page 113 for more information.	Preferred: $100 per admission copayment for unlimited days Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment ***Note:*** If you are admitted to a Non-member facility due to a **medical emergency or accidental injury**, you pay a $300 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred: $100 per day copayment up to $500 per admission for unlimited days Member/Non-member: You pay all charges

Inpatient hospital – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below, "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Inpatient hospital *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic laboratory tests, pathology services, MRIs, machine diagnostic tests, and X-rays • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process • Nutritional counseling • Acute inpatient rehabilitation ***Note:*** Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days. • We pay inpatient hospital benefits for an admission in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(h). ***Note:*** See pages 32-33 for other covered maternity services. ***Note:*** See page 42 for coverage of blood and blood products.	Preferred: $100 per admission copayment for unlimited days ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility. Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission for unlimited days ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered services is limited to $100 per admission. Member/Non-member: You pay all charges

Inpatient hospital – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Inpatient hospital *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: *Hospital room and board expenses when, in our judgement, a hospital admission or portion of an admission is:* • *Custodial or long term care* • *Convalescent care or a rest cure* • *Domiciliary care provided because care in the home is not available or unsuitable* • *Not medically necessary, such as when services did not require the acute/subacute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:* – *Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)* – *Admissions primarily for diagnostic studies, laboratory and pathology services, X-rays, MRIs, or machine diagnostic tests that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)* ***Note:** If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.* • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Inpatient private duty nursing*	*All charges*	*All charges*

Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Outpatient hospital or ambulatory surgical center	You Pay	
	Standard Option	**Basic Option**
Outpatient **medical services** performed and billed by a hospital or freestanding ambulatory facility, such as: • Use of special treatment rooms • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Chemotherapy and radiation therapy • Intravenous (IV)/infusion therapy • Cardiac rehabilitation • Pulmonary rehabilitation • Physical, occupational, and speech therapy • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency medical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen *Note:* See pages 29-31 for covered preventive services for adults and children. *Note:* See pages 68-72 for our payment levels for care related to a medical emergency or accidental injury.	Preferred facilities: 10% of the Plan allowance (calendar year deductible applies) *Note:* For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 10% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility. Member facilities: 25% of the Plan allowance (calendar year deductible applies) Non-member facilities: 25% of the Plan allowance; plus any difference between our allowance and the billed amount (calendar year deductible applies) *Note:* See page 37 for our coverage of physical, occupational, and speech therapy.	Preferred: $40 copayment per day per facility (except for diagnostic tests as noted below) Member/Non-member: You pay all charges (except for diagnostic tests as noted below) *Note:* For outpatient diagnostic tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. *Note:* For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility.

Outpatient hospital or ambulatory surgical center – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Outpatient hospital or ambulatory surgical center *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Outpatient **surgery and related services** performed and billed for by a hospital or freestanding ambulatory facility, such as: • Operating, recovery, and other treatment rooms • Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Facility supplies for hemophilia home care • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Visits to the outpatient department of a hospital for non-emergency surgical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen ***Note:*** See page 64 for outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility. ***Note:*** See pages 68-72 for our payment levels for care related to a medical emergency or accidental injury. ***Note:*** We cover outpatient hospital services and supplies related to dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(h), *Dental benefits*, for additional benefit information. ***Note:*** See pages 32-33 for other covered maternity services.	Preferred facilities: 10% of the Plan allowance ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 10% coinsurance amount and pay for covered services in full when you use a Preferred facility. Member facilities: 25% of the Plan allowance Non-member facilities: 25% of the Plan allowance; plus any difference between our allowance and the billed amount	Preferred: $40 copayment per day per facility (except for diagnostic tests as noted below) Member/Non-member: You pay all charges (except for diagnostic tests as noted below) ***Note:*** For outpatient diagnostic tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. ***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility.

Outpatient hospital or ambulatory surgical center – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Outpatient hospital or ambulatory surgical center *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Outpatient **drugs, medical devices, and durable medical equipment** billed for by a hospital or freestanding ambulatory facility, such as: • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment	Preferred facilities: 10% of the Plan allowance (calendar year deductible applies) ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 10% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility. Member facilities: 25% of the Plan allowance (calendar year deductible applies) Non-member facilities: 25% of the Plan allowance; plus any difference between our allowance and the billed amount (calendar year deductible applies)	Preferred: 30% of the Plan allowance ***Note:*** You may also be responsible for paying a $40 copayment per day per facility for outpatient services. Member/Non-member: You pay all charges ***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility.

Note: The Standard Option calendar year deductible applies ONLY when we say below "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Extended care benefits/Skilled nursing care facility benefits	You Pay	
	Standard Option	**Basic Option**
Limited to the following benefits for Medicare Part A copayments: When Medicare Part A is the primary payer (meaning that it pays first) and has made payment, **Standard Option** provides limited secondary benefits. We pay the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases. If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day. ***Note:*** See page 37 for benefits provided for outpatient physical, occupational, and speech therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note:*** **If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.**	Preferred: Nothing Participating/Member: Nothing Non-participating/Non-member: Nothing ***Note:*** You pay all charges not paid by Medicare after the 30th day.	*All charges*

Note: The Standard Option calendar year deductible applies ONLY when we say below "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Hospice care	You Pay	
	Standard Option	**Basic Option**
Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients in their homes. We provide the following **home hospice care** benefits for members with a life expectancy of six months or less **when prior approval is obtained from the Local Plan** and the home hospice agency is approved by the Local Plan: • Physician visits • Nursing care • Medical social services • Physical therapy • Services of home health aides • Durable medical equipment rental • Prescription drugs • Medical supplies	Nothing	Nothing
Inpatient hospice for members receiving home hospice care benefits: Benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility. Each inpatient stay must be separated by at least 21 days. These covered inpatient hospice benefits are available only when inpatient services are necessary to: • control pain and manage the patient's symptoms; or • provide an interval of relief (respite) to the family *Note:* **You are responsible for making sure that the home hospice care provider has received prior approval from the Local Plan** (see page 13 for instructions). Please check with your Local Plan and/or your PPO directory for listings of approved agencies.	Preferred: $100 per admission copayment Member: $300 per admission copayment Non-member: $300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission Member/Non-member: You pay all charges
Not covered: Homemaker or bereavement services	*All charges*	*All charges*

Note: The Standard Option calendar year deductible applies ONLY when we say below "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Ambulance	You Pay	
	Standard Option	**Basic Option**
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care	Preferred: 10% of the Plan allowance Participating/Member: 10% of the Plan allowance Non-participating/Non-member: 10% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $50 copayment per trip Participating/Member or Non-participating/Non-member: $50 copayment per trip
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury	Preferred: Nothing (No deductible) Participating/Member: Nothing (No deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $50 copayment per trip Participating/Member or Non-participating/Non-member: $50 copayment per trip

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $250 per person ($500 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings. [See Section 5(h) for dental care for accidental injury.]

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Basic Option benefits for emergency care

Under Basic Option, you are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the **initial** treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. We will also provide benefits if you are admitted directly to the hospital from the emergency room until your condition has been stabilized. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Benefit Description	Standard Option	Basic Option
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.	**You Pay**	
Accidental injury		
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient **hospital services** and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests ***Note:*** We pay Inpatient professional and hospital benefits if you are admitted [see Sections 5(a), 5(b), and 5(c)]. ***Note:*** See Section 5(h) for dental benefits for accidental injuries.	Preferred: Nothing (No deductible) Participating/Member: Nothing (No deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.	Preferred emergency room: $50 copayment per visit Participating/Member emergency room: $50 copayment per visit Non-participating/Non-member emergency room: $50 copayment per visit ***Note:*** You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $50 emergency room copayment. However, the $100 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Accidental injury – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Accidental injury *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
		For the following places of service, you **must** receive care from a Preferred provider: **Preferred** urgent care center: $30 copayment per visit **Preferred** primary care provider or other health care professional's office: $20 copayment per visit **Preferred** specialist's office: $30 copayment per visit Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges
Not covered: • *Oral surgery except as shown in Section 5(b)* • *Injury to the teeth while eating*	*All charges*	*All charges*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Medical emergency	You Pay	
	Standard Option	**Basic Option**
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient **hospital services** and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests ***Note:*** We pay Inpatient professional and hospital benefits if you are admitted as a result of a medical emergency [see Sections 5(a), 5(b), and 5(c)]. ***Note:*** Please refer to Section 3 for information about precertifying emergency hospital admissions.	Preferred: 10% of the Plan allowance ***Note:*** If you receive services in a Preferred physician's office, you pay a $15 copayment (No deductible) for the office visit, and 10% of the Plan allowance for all other services (deductible applies). Participating/Member: 25% of the Plan allowance Non-participating/Non-member: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** These benefit levels **do not** apply if you receive care in connection with, and within 72 hours after, an accidental injury. See Accidental Injury benefits on pages 68-70 for the benefits we provide.	Preferred emergency room: $50 copayment per visit Participating/Member emergency room: $50 copayment per visit Non-participating/Non-member emergency room: $50 copayment per visit ***Note:*** You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $50 emergency room copayment. However, the $100 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. For the following places of service, you **must** receive care from a Preferred provider: **Preferred** urgent care center: $30 copayment per visit **Preferred** primary care provider or other health care professional's office: $20 copayment per visit **Preferred** specialist's office: $30 copayment per visit Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Ambulance	You Pay	
	Standard Option	**Basic Option**
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care *Note:* See Section 5(c) for non-emergency ambulance services.	Preferred: 10% of the Plan allowance (No deductible) Participating/Member: 10% of the Plan allowance (No deductible) Non-participating/Non-member: 10% of the Plan allowance, plus any difference between our allowance and the billed amount (No deductible)	Preferred: $50 copayment per trip Participating/Member or Non-participating/Non-member: $50 copayment per trip
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury	Preferred: Nothing (No deductible) Participating/Member: Nothing (No deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible) *Note:* These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $50 copayment per trip Participating/Member or Non-participating/Non-member: $50 copayment per trip

Section 5(e) Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under **Standard Option**, the calendar year deductible or, for facility care, the inpatient per admission copay, applies to almost all benefits in this Section. We added "(No deductible)" to show when the deductible does not apply.
- **Under Standard Option,** there is a maximum of 25 visits per year for office visits, partial hospitalization, intensive outpatient treatment, and other hospital outpatient treatment. The first 25 visits under Standard Option each calendar year by Preferred providers and Non-preferred providers count toward this maximum. This maximum may be waived for services received from Preferred providers.
- Under **Standard Option**, you may choose to get care In-Network (Preferred) or Out-of-Network (Non-preferred). When you use a Preferred provider, he or she must submit a treatment plan to us **prior to your ninth outpatient visit** in order to maximize the benefits you receive. Preferred benefits are payable when the care is clinically appropriate to treat your condition and when you receive the care as part of a treatment plan that we approve. Cost-sharing and limitations for In-Network (Preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option, you must call us for prior approval before receiving care.** We will provide you with the names and phone numbers of several Preferred providers and tell you how many visits we are initially approving. You may then choose which of those providers you would like to see. **You must use Preferred providers in order to receive Basic Option benefits.**
- **Under Basic Option**, there is **no calendar year deductible**.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3. Some other services also require prior approval. See the instructions after the benefits descriptions below.
- **Standard Option and Basic Option benefits** for Preferred (In-Network) mental health and substance abuse care begin below and are continued on the following pages. Standard Option benefits for Non-preferred (Out-of-Network) care begin on page 77.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.		
Preferred (In-Network) benefits	**Standard Option**	**Basic Option**
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. *Note:* Preferred benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care from a Preferred provider as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.

Preferred (In-Network) benefits – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Preferred (In-Network) benefits *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, clinical social workers, or psychiatric nurses • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation *Note:* Additional types of licensed providers may be available to you for mental health and substance abuse services. Consult your PPO directory or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card.	$15 copayment for the visit, up to two hours per visit (No deductible)	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit *Note:* You pay a $40 copayment for outpatient services billed for by a facility. *Note:* You pay 30% of the Plan allowance for drugs and supplies.
• Pharmacotherapy (medication management) • Psychological testing (not subject to the two-hour limit)	Preferred: $15 copayment for the office visit charge (No deductible)	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit *Note:* You pay 30% of the Plan allowance for drugs and supplies.
• Inpatient professional visits • Professional charges for facility-based intensive outpatient treatment	10% of the Plan allowance *Note:* Intensive outpatient treatment is not limited to two hours per visit but you must obtain prior approval.	Nothing
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting	10% of the Plan allowance *Note:* Intensive outpatient treatment is not limited to two hours per visit but you must obtain prior approval.	Preferred: $30 copayment per visit
• Professional charges for outpatient diagnostic tests	10% of the Plan allowance	Nothing

Preferred (In-Network) benefits – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Preferred (In-Network) benefits *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Diagnostic tests ***Note:*** You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$100 per admission copayment (No deductible)	$100 per day copayment up to $500 per admission
Outpatient services provided and billed by a hospital or other covered facility • Diagnostic tests • Services in the following approved treatment programs (must be prior approved): – partial hospitalization – facility-based intensive outpatient treatment	10% of the Plan allowance	$40 copayment per day per facility ***Note:*** You pay 30% of the Plan allowance for drugs.
Not covered: • *Services we have not approved* • *Educational or training services* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present*	*All charges*	*All charges*

Preferred (In-Network) benefits – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Preferred (In-Network) benefits *(continued)*

Authorization Procedures	**Standard Option:** To be eligible to receive Preferred mental health and substance abuse benefits you must see a Preferred provider, obtain a treatment plan, and follow the applicable authorization processes. To locate a Preferred provider, please refer to your PPO directory, visit our Web site at www.fepblue.org, or contact us at the mental health and substance abuse phone number shown on the back of your ID card. **Basic Option:** To be eligible to receive mental health and substance abuse benefits, you must call us for prior approval at the mental health and substance abuse phone number on the back of your ID card before you receive care. We will then provide you with the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving.
Precertification	You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty. Please refer to the precertification information listed in Section 3 for additional information.
Prior Approval	**Standard Option:** Prior approval is required for partial hospitalization and intensive outpatient treatment programs. **Basic Option:** Prior approval is required for all mental health and substance abuse services. Prior to starting treatment, you, someone acting on your behalf, your physician, or your hospital must call us at the mental health and substance abuse phone number on the back of your ID card. We will not pay for mental health and substance abuse services under Basic Option or for partial hospitalization or intensive outpatient treatment programs under Standard Option, even at Preferred facilities, until you obtain prior approval.
Treatment Plans	**Standard Option: We provide Preferred benefits only when you receive care as part of a treatment plan that we have approved.** In order to maximize your benefits, your provider must submit a treatment plan to us **prior to your ninth outpatient visit**. When we approve the treatment plan, we will give your provider authorization for additional visits or services. The services or number of additional visits authorized will depend on the treatment plan. We may need to request updated treatment plans as your treatment progresses. If a treatment plan is not submitted or approved, we will provide only Non-preferred (out-of-network) benefits. If you change providers, a new treatment plan must be submitted. We will be flexible in allowing additional visits while your treatment plan is being prepared or under review. **Basic Option:** We will work directly with your provider and may request a treatment plan from your provider. OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
Preferred Limitation	**Under Standard Option,** if you do not obtain an approved treatment plan, we will provide only Non-preferred (out-of-network) benefits.

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Non-preferred (Out-of-Network) benefits	You Pay	
	Standard Option	**Basic Option**
Professional services, including individual or group therapy, by providers such as psychiatrists, psychologists, clinical social workers, or psychiatric nurses, for: • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation	40% of the Plan allowance for up to two hours per visit and up to 25 outpatient visits per calendar year; all charges after 25 visits*. You may also be responsible for any difference between the Plan allowance and the billed amount. *The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	Participating/Non-participating: You pay all charges
Other services: • Pharmacotherapy (medication management) • Psychological testing	25% of the Plan allowance. You may also be responsible for any difference between the Plan allowance and the billed amount. ***Note:*** Other services are not subject to the 25-visit limitation.	Participating/Non-participating: You pay all charges
Inpatient visits	40% of the Plan allowance up to 100 days per calendar year; all charges after 100 days. You may also be responsible for any difference between the Plan allowance and the billed amount.	Participating/Non-participating: You pay all charges

Non-preferred (Out-of-Network) benefits – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Non-preferred (Out-of-Network) benefits *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$400 copayment per day (No deductible) up to 100 days per calendar year, plus any difference between our allowance and the billed amount; all charges after 100 days	Member/Non-member: You pay all charges
Outpatient services provided and billed by a hospital or other covered facility • Psychological testing	25% of the Plan allowance, plus any difference between the Plan allowance and the billed amount ***Note:*** Psychological testing is not subject to the visit limitations.	Member/Non-member: You pay all charges
Partial hospitalization and intensive outpatient treatment	25% of the Plan allowance, plus any difference between the Plan allowance and the billed amount; all charges after 25 visits* ***Note:*** Visits that you pay for while meeting your deductible count toward the limit cited above. *The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	Participating/Member or Non-participating/Non-member: You pay all charges

Non-preferred (Out-of-Network) benefits – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Non-preferred (Out-of-Network) benefits *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	Non-preferred facility: $400 copayment per day, plus any difference between our allowance and the billed amount (No deductible); all charges after 28 days per lifetime Non-preferred professional: 40% of the Plan allowance; all charges after 28 days per lifetime. You may also be responsible for any difference between the Plan allowance and the billed amount. ***Note:*** Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime.	Member/Non-member: You pay all charges Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services* • *Services performed by a noncovered provider* • *Testing and treatment for learning disabilities and mental retardation* • *Services performed or billed by schools, residential treatment centers, halfway houses, or members of their staffs* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present*	*All charges*	*All charges*

Lifetime maximum

Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime under **Standard Option**.

Precertification

You must get precertification of the medical necessity of your admission to a hospital or other covered facility. Report emergency admissions within two business days following the day of admission, even if you have been discharged. Otherwise, we will reduce the benefits payable by $500. See Section 3 for more information on precertification.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about catastrophic protection for mental health and substance abuse benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting Non-preferred claims.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 82.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program or Mail Service Prescription Drug Program. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,** there is **no calendar year deductible.**
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS, and prior approval must be renewed periodically. Please refer to the prior approval information shown on page 86 of this Section and in Section 3.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. See page 86 of this Section for more information about this important program.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **Under Standard Option,** PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 11 for the exceptions to this requirement.**
- Please note that retail pharmacies and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. Refer to page 83 for information about locating Preferred pharmacies.
- **Under Standard Option,** you may use the Mail Service Prescription Drug Program to fill your prescriptions.
- **Under Basic Option,** the Mail Service Prescription Drug Program **is not** available.

We will send each new enrollee a combined prescription drug/Plan identification card. Standard Option members are eligible to use the Mail Service Prescription Drug Program and will also receive a mail service order form and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States or Puerto Rico, or a nurse practitioner in states that permit it, must write your prescriptions [see Section 5(i) for drugs purchased overseas].
- **Where you can obtain them.**

  Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, through a Preferred internet pharmacy, at a Non-preferred retail pharmacy, or through our Mail Service Prescription Drug Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, a Preferred internet pharmacy, or our Mail Service Prescription Drug Program.

  Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy or through a Preferred internet pharmacy in order to receive benefits.
- **We use an open formulary.** This is a list of preferred drugs selected to meet patient needs at a lower cost to us. If your physician believes a brand-name drug is necessary or there is no generic equivalent available, ask your physician to prescribe a brand-name drug from our formulary list.

  Under Standard Option, we may ask your doctor to substitute a formulary drug in order to help control costs. We cover drugs that require a prescription (whether or not they are on our formulary list). Your cooperation with our cost-savings efforts helps keep your premium affordable.

Under Basic Option, we encourage you to ask your physician to prescribe a brand-name drug from our formulary when your physician believes a brand-name drug is necessary or when there is no generic equivalent available. If you purchase a drug that is not on our formulary list, your cost will be higher. (We cover drugs that require a prescription whether or not they are on our formulary list.)

Note: Before filling your prescription, please check the formulary status of your medication. Other than changes resulting from new drugs or safety issues, the formulary list is updated twice a year. Prescription drugs are reviewed by the Plan for safety and clinical efficacy. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. Using lower cost formulary drugs will provide you with a high quality, cost-effective prescription drug benefit.

You can view our formulary on our Web site at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

  Standard Option: By submitting your prescription (or those of family members covered by the Plan) to your retail pharmacy or the Mail Service Prescription Drug Program, you authorize them to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

  Basic Option: By filling your prescriptions (or those of family members covered by the Plan) at a Preferred retail pharmacy or through a Preferred internet pharmacy, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. In most cases, they must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration (FDA) sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

  You can save money by using generic drugs. However, you and your doctor have the option to request a brand-name drug even if a generic option is available. Using the most cost-effective medication saves money.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.

- **These are the dispensing limitations.**

  Standard Option: You may purchase **up to** a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program. You may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

  Basic Option: When you fill a prescription for the first time, you may purchase **up to** a 34-day supply for a single copayment. For additional copayments, you may purchase **up to** a 90-day supply for continuing prescriptions and for refills.

Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. In most cases, refills cannot be obtained until 75% of the prescription has been used. Call us or visit our Web site if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs. See the contact information below.

- **Important contact information.**

  Standard Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-866-409-8525); or www.fepblue.org.

  Basic Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077) or www.fepblue.org.

Covered medications and supplies	You Pay	
	Standard Option	Basic Option
• Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase *Note:* See Section 5(a), page 42, for our coverage of medical foods for children with inborn errors of amino acid metabolism and for medical foods and nutritional supplements when administrated by catheter or nasogastric tube. • Insulin • Needles and disposable syringes for the administration of covered medications • Drugs to aid smoking cessation that require a prescription by Federal law *Note:* Prior approval is required if drug treatment extends beyond the initial course of treatment. See Section 3 for more information. • Contraceptive drugs and devices, limited to: – Depo-Provera* – Diaphragms and contraceptive rings* – Intrauterine devices (IUDs) – Implantable contraceptives* – Oral and transdermal contraceptives *available only through retail and internet pharmacies *Note:* See Family planning in Section 5(a).	See following pages	See following pages

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Here is how to obtain your prescription drugs and supplies: **Preferred Retail Pharmacies** • Make sure you have your Plan ID card when you are ready to purchase your prescription • Go to any Preferred retail pharmacy, or • Visit our Web site, www.fepblue.org, click on "Pharmacy Programs," and follow the FEP Retail Pharmacy Providers link to fill your prescription and receive home delivery • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site, www.fepblue.org ***Note:*** Please be sure to request the Preferred retail or internet pharmacy listing for your specific option. Retail and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. ***Note:*** Retail and internet pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies. ***Note:*** For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for retail pharmacy-obtained prescription drugs, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077). **For benefit information about prescription drugs supplied by Non-preferred pharmacies, please refer to the next page.** ***Note:*** For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payer, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site at www.fepblue.org.	25% of the Plan allowance	**First-time purchase of a new prescription** up to a 34-day supply: Generic drug: $10 copayment Formulary brand-name drug: $30 copayment Non-formulary brand-name drug: 50% of Plan allowance ($35 minimum) **Refills or continuing prescriptions** up to a 90-day supply: Generic drug: $10 copayment for each purchase of up to a 34-day supply ($30 copayment for 90-day supply) Formulary brand-name drug: $30 copayment for each purchase of up to a 34-day supply ($90 copayment for 90-day supply) Non-formulary brand-name drug: 50% of Plan allowance ($35 minimum for each purchase of up to a 34-day supply, or $105 minimum for 90-day supply) ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug. ***Note:*** For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount noted above, you pay only the cost of your prescription.

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	**Basic Option**
Non-preferred Retail Pharmacies	45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount ***Note:*** If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.	*All charges*
Mail Service Prescription Drug Program Under Standard Option, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills. Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program. ***Note:*** Not all drugs are available through the Mail Service Prescription Drug Program.	Mail Service Program: $10 generic $35 brand-name ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug. ***Note:*** If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.	No benefit ***Note:*** You may request home delivery of your internet prescription drug purchases. See page 83 of this Section for our payment levels for drugs obtained through Preferred retail and internet pharmacies.

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Drugs from other sources • Covered prescription drugs and supplies not obtained at a retail pharmacy, through an internet pharmacy, or, for Standard Option only, through the Mail Service Prescription Drug Program *Note:* Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. *Note:* For covered prescription drugs and supplies purchased outside of the United States and Puerto Rico, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services. • Please refer to the Sections indicated for additional benefit information when you purchase drugs from a: – Physician's office – Section 5(a) – Hospital (inpatient or outpatient) – Section 5(c) – Hospice agency – Section 5(c) • Please refer to page 83 for retail pharmacy-obtained prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility	Preferred: 10% of the Plan allowance (calendar year deductible applies) Participating/Member: 25% of the Plan allowance (calendar year deductible applies) Non-participating/Non-member: 25% of the Plan allowance (calendar year deductible applies); plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Member or Non-participating/Non-member: You pay all charges

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	Basic Option
Patient Safety and Quality Monitoring (PSQM) We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include: • Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them. • Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills. • Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines. For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our Web site at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). **Prior Approval** As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), **you must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage**. Prior approval must be renewed periodically. To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our Web site at www.fepblue.org. Please read Section 3 for more information about prior approval. ***Note:*** If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.		

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs and supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your State law* **Note:** See Section 5(a), page 42, for our coverage of medical foods for children with inborn errors of amino acid metabolism and for medical foods and nutritional supplements when administrated by catheter or nasogastric tube. • *Drugs for which prior approval has been denied or not obtained* • *Infant formula other than described on page 42* • *Drugs and supplies related to sex transformations, sexual dysfunction, or sexual inadequacy* • *Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States*	*All charges*	*All charges*

Section 5(g) Special features

Flexible benefits option	Under the Blue Cross and Blue Shield Service Benefit Plan, our Case Management process includes a **flexible benefits option**. This option allows nurse case managers at Local Plans to assist members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the member. Members who are eligible to receive benefits through the flexible benefits option are asked to provide verbal consent for the alternative plan. If you and your provider agree with the plan, alternative benefits will begin immediately and you will be asked to sign an **alternative benefits agreement** that includes the terms listed below. • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with the review process. • If we approve alternative benefits, we cannot guarantee that they will be extended beyond the limited time period and/or scope of treatment initially approved or that they will be approved in the future. • The decision to offer alternative benefits is solely ours, and unless otherwise specified in the **alternative benefits agreement**, we may withdraw those benefits at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. If you sign the **alternative benefits agreement**, we will provide the agreed-upon benefits for the stated time period, unless we are misled by the information given to us. You may request an extension of the time period initially approved for alternative benefits, but benefits as stated in this brochure will apply if we do not approve your request. Please note that the written **alternative benefits agreement** must be signed by the member or his/her authorized representative and returned to the Plan case manager within 30 days of the date of the alternative benefits agreement. If the Plan does not receive the signed agreement within 30 days, alternative benefits will be withdrawn and benefits as stated in this brochure will apply.
Online customer and claims service	By visiting our Web site, www.fepblue.org, you may check the status of your claims, change your address of record, request claim forms, request a duplicate or replacement Service Benefit Plan ID card, and access a range of other service and information options. It's easy! Give it a try and share any suggestions you may have for improved service by using the site's "Contact Us" feature.
24-hour nurse line	Help with health concerns is available 24 hours a day, 365 days a year, by calling a toll-free telephone number, 1-888-258-3432, or by accessing our Web site, www.fepblue.org. The service, called Blue Health Connection, offers health advice or health information and counseling by registered nurses. Also available is the AudioHealth Library with hundreds of tapes, ranging from first aid to infectious diseases to general health issues. Please keep in mind that benefits for any health care services you may seek after using Blue Health Connection are subject to the terms of your coverage under this Plan.
Services for the deaf and hearing impaired	All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.
Web accessibility for the visually impaired	Our Web site provides visually impaired individuals with access to important program information and services. Look for the "Web Accessibility" option at www.fepblue.org.
Travel benefit/services overseas	Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States and Puerto Rico.
Health support programs	The Service Benefit Plan offers patient education and support programs for certain diagnoses in select locations. Call the customer service number on the back of your ID card to find out what programs are available in your area.
Healthy Families Program	Healthy Families is a national health education prevention program that provides educational mailings to members and their families to help adopt healthy behaviors, reduce risk of injury and disease, and improve existing chronic conditions.

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible applies only to the accidental injury benefit below. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- ***Note:*** We cover inpatient and outpatient hospital care for dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered). See Section 5(c) for inpatient and outpatient hospital benefits.

Accidental injury benefit	You Pay	
	Standard Option	**Basic Option**
We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. ***Note:*** An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. ***Note:*** A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.	Preferred: 10% of the Plan allowance (calendar year deductible applies) Participating: 25% of the Plan allowance (calendar year deductible applies) Non-participating: 25% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	$20 copayment ***Note:*** **We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers.** See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Dental benefits – continued on next page

Dental benefits

What is Covered

Standard Option dental benefits are presented in the chart beginning below and continuing on the following pages.

Basic Option dental benefits appear on page 94.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and Basic Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you, refer to the Preferred provider directory, visit our Web site at www.fepblue.org, or call us at the customer service number on the back of your ID card. You can also call us to obtain a copy of the applicable MAC listing.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

Standard Option dental benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances below and on the following pages. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. When you use Non-preferred dentists, you pay all charges in excess of the listed fee schedule amounts. For Preferred dentists, you pay the difference between the fee schedule amount and the MAC (see above).

Standard Option dental benefits	Standard Option Only		
Covered service	We pay		You pay
Clinical oral evaluations	**To age 13**	**Age 13 and over**	
Periodic oral evaluation*	$12	$8	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
**Limited to two per person per calendar year*			

Dental benefits – continued on next page